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ABSTRACT

This monograph is the fourth year report of the Health and Education Collaboration Project, directed by the Hawaii Medical Association, with the purpose of developing, testing, and disseminating a model for family-centered, interprofessional training and service delivery. At the center of the demonstration effort is the Healthy and Ready to Learn Center, offering family-centered services from an interprofessional and collaborative model, an emergent model of support based on the understanding that children grow up in complex environments. The sections of the report are as follows: (1) "What is Family-Centered Interprofessional Collaboration?"; (2) "Principles of Family-Centered Interprofessional Collaboration"; (3) "The Health and Education Collaboration Project Background"; (4) "Implementation of Family-Centered Interprofessional Collaboration" (Year One, Year Two, Year Three, Year Four); (5) "Developmental Stages and Lessons Learned"; (6) "Sustainability"; (7) "Implications for Future Interprofessional Collaboration Efforts"; and (8) "Learning Examples of Family-Centered Interprofessional Collaboration." Appendices include information on training, project updates, and project committee members. (KB)

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Lessons Learned in Family-Centered Interprofessional Collaboration

Year Four

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A Message from Calvin C.J. Sia, M.D.

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Calvin C.J. Sia, M.D.
Principal Investigator

Preface

Bridging Out: Lessons Learned in Family-Centered Interprofessional Collaboration is the Year Four report of a committed group of families, administrators, staff, faculty, and students working together to address health and education issues faced by children and their families and to prevent more complex problems from developing. In this final report, the Health and Education Collaboration Project (HEC) focuses on community-based university education as an effective strategy for training new practitioners. Central to the family-centered interprofessional curriculum and practicum experience is the understanding that family empowerment and professional collaboration serve as building blocks to help families. Family-centered interprofessional curricula and practica must be integrated within individual university colleges. A new generation of professionals who acquire the knowledge, skills, and values of family-centered interprofessional collaboration can transform the traditional system of care. Their new beliefs will lead to effective, skilled, and caring family/professional interactions which will change the plight of children and families in the 21st century.

. . . We have learned to create the small exceptions that can change the lives of hundreds. But we have not learned how to make [those] exceptions the rule to change the lives of millions.

Schorr, 1997

This monograph is the result of a grant from Maternal and Child Health Bureau (MCHB). The purpose of the MCHB funding initiative is three fold:

1. to demonstrate the ability of health, social service, and education professionals to work together in communities to foster successful physical, social, and emotional growth for children and their families;
2. to assist in the development of curricula based on best practices learned in community settings; and
3. to disseminate a collaborative model of personnel training and service delivery at the regional, state, and national levels.

The initiative grew out of the recommendations of Healthy People 2000, and the resulting objectives are identified in the *National Agenda for Children with Special Health Care Needs: Achieving the Goals 2000*. One of the latter's objectives is to create a collaborative health, education, and human services system for children, including those with special needs, and their families. In keeping with this national agenda, HEC has developed a personnel preparation model that promotes working relationships among trained collaborative providers and keeps families pivotal to the process. With the HEC community-based project, two other university-based programs were funded by MCHB to target university schools of social work, education, and medicine. The three demonstration projects are:

- **Health and Education Collaboration Project**, Hawaii Medical Association. Principal Investigator: Calvin C.J. Sia, M.D. Project Director: Sharon Taba. Co-Project Director: Louise Iwaishi, M.D.
- **Partnerships for Change**, Department of Social Work, University of Vermont. Project Director: Kathleen Kirk Bishop, D.S.W.
- **Higher Education Curricula for Integrated Service Providers Project**, Teaching Research Division, Western Oregon State College. Project Director: Vic Baldwin, Ph.D.

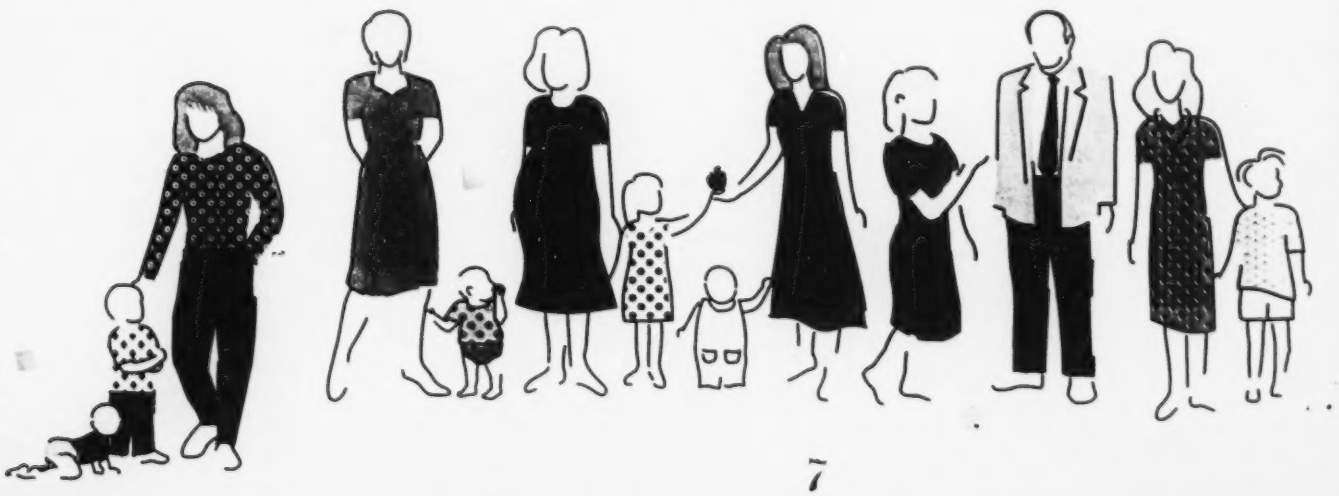
What Is Family-Centered Interprofessional Collaboration?

Family-Centered Interprofessional Collaboration is a human services approach based on the belief that professionals from diverse disciplines such as health, education, and social work can accomplish more by working in partnerships together with families than they can apart.

Family-centered care refers to the concept that recognizes and builds upon families' strengths and resiliency to meet their needs and aspirations. Family-centered practitioners respect families' history, culture, language, priorities, and practices. Family-centered practitioners also recognize that the family is the constant in their child's life, and they understand that families make the final decisions for themselves and their children.

Interprofessional collaboration refers to professionals from diverse areas of expertise working together with families to benefit children and families. Interprofessional practitioners develop and nurture trust within their partnerships. They, too, learn to respect one another's history, culture, language, and practices. Interprofessional collaboration is not an end in itself. It is a methodology for helping families accomplish their goals in comprehensive and integrated ways.

Family-centered interprofessional collaboration marries the principles of both family-centered care and interprofessional collaboration into a comprehensive approach to partnerships among families and human service professionals. It is the teamwork and care that professionals and families offer to one another that enables all to identify, understand, and reach goals that ultimately benefit children and families.



Principles of Family-Centered Interprofessional Collaboration

The principles are adapted from monographs developed by Kathleen Kirk Bishop, D.S.W., Josie Woll, and Polly Arango (1993) and Katharine Hooper-Briar and Hal A. Lawson (1994).

Family-Centered Interprofessional Collaboration

1. Promotes a relationship in which family members and professionals work together to ensure interagency coordination to provide improved services for the child and family.
2. Recognizes and respects the knowledge, skills, and experience that families and professionals from all disciplines bring to the relationship.
3. Acknowledges that the development of trust is an integral part of the collaborative relationship.
4. Facilitates open communication so that families and professionals feel free to express themselves.
5. Creates an atmosphere in which the cultural traditions, values, and diversity of families and professionals are acknowledged and honored.
6. Recognizes that negotiation is essential in a collaborative relationship.
7. Brings to collaborative relationships the mutual commitment of families, professionals, and communities to meet the needs of children and their families through a shared vision of how things could be different and better.

Health and Education Collaboration Project Background

The Health and Education Collaboration Project (HEC) was created to identify, develop, and promote key aspects of training for interprofessional collaborative practice. HEC identified the community-based Healthy and Ready to Learn Center (HRTL) as a key training, research, and program development site for the first three years of the project. During its fourth and final year, HEC ventured out in search of other sites to test the viability of the training developed in the first three years and to adapt the practicum to the selected sites.

During the first three years, the HRTL health, education, and support services included prenatal and postpartum care, family spacing, routine well-child care, child development support, parent-child activities, supportive counseling, and referral services. The HRTL interprofessional team, comprised of a nurse practitioner, social worker, and early childhood educator, worked together to ensure that services were provided with a family-centered interprofessional collaboration approach. Simply, this meant that families and professionals were empowered in decision-making to obtain the best possible care for their children.

Initially, HEC brought together a consortium of supporting agencies:

- **Consuelo Zobel Alger Foundation** served as the operating foundation for HRTL.
- **Hawaii Medical Association** (HMA), a professional physician organization, primarily developed the model program.
- **Kapiolani Medical Center for Women and Children** (KMCWC), a teaching hospital, provided preventive health services, including physician coverage and two HRTL staff positions, at HRTL.
- **University of Hawaii John A. Burns School of Medicine, Departments of Pediatrics and Obstetrics-Gynecology** assigned faculty and residents to provide medical services and to participate in HRTL clinical rotations.
- **Child and Family Service** (CFS), the largest private social service agency in Hawaii, opened its first comprehensive family center in Leeward Oahu in 1997 and committed to sustaining the HRTL program.

Zero-to-Three Hawai'i Project

Implementation of Family-Centered Interprofessional Collaboration

The first three years at HRTL focused on three goals: 1) identifying and implementing key elements of collaboration; 2) incorporating five major concepts – family-centered care, interprofessional collaboration, interprofessional communication, the medical home, and early childhood education as prevention – in systematic training, and 3) creating resident rotations and early childhood education and social work practica around the principles of family-centered interprofessional collaboration.

Training was based on several assumptions: 1) early and appropriate training is central to a successful shift from traditional to interprofessional service delivery (*Building Bridges, Year 1*); 2) community-based models of collaborative training are recommended for pre-service and in-service professionals but can be difficult to develop (Bailey, 1996); and 3) professionals working together with families can maximize positive outcomes for young children.

Year One (1994-1995)

In Year One, HEC initiated medical resident rotations as part of two programs within the University of Hawaii (UH) John A. Burns School of Medicine (Pediatrics and Obstetrics and Gynecology) and partnered with UH pediatric faculty. With UH faculty and HRTL staff, HEC co-developed an emergent training using a compendium of articles on collaboration from health, education, and social work literature and annotated bibliographies researched by members of the National Commission on Leadership in Interprofessional Education (NCLIE) and two sister projects. The pediatric faculty's primary question throughout was how the family-centered collaborative practice fit with other high-paced, life-and-death type pediatric resident rotations. HEC also cultivated relationships with the deans and faculty in the UH School of Social Work and College of Education for the eventual placement of social work and education students in collaborative practica.

Year Two (1995-1996)

During Year Two, HEC continued training development with HRTL. Resident rotations and nursing and social work practica were tailored to the HRTL Center. HRTL staff developed cross-disciplinary experiences for the students. HEC and HRTL staff co-taught residents from a training guide prepared from the previous year's service and training experience. The resident rotation expanded to include a family home visit and a site visit to an infant development program to show residents the continuum of services for families. HEC staff worked with HRTL to integrate the students' experiences. HEC also disseminated its collaborative model to new audiences including local community service providers, university pediatric, ob-gyn, and social work faculty, and national university audiences convened by the NCLIE.

Year Three (1996-1997)

During Year Three, the long-planned transition of the administration of HRTL from the Hawaii Medical Association (HMA) to Child and Family Service (CFS) created an evaluative

Two elements are essential for implementing community-based education programs: a vision of how community experiences fit into the training of the health professional of the future and a local environment that will support innovation, change, and growth.

Osborn, 1996

climate, with HRTL sponsors questioning the program/training direction. While CFS took the lead in answering those questions, HEC continued to focus on HRTL staff experiences to refine the training guide. At the end of Year Three, HRTL staff preceptors assumed the primary roles as trainers, while HEC's role shifted to support. HRTL's greatest training challenges were 1) reinforcing the importance of teaming, especially with professionals traditionally not trained to team, and 2) balancing their own service and training requirements. Residents were assigned new teaching roles – in parent education and support groups – to give them a better understanding of families as they addressed "real world" and clinical questions and interests.

Year Four (1997-1998) – Challenges of Developing Community-Based University Education

The greatest difficulty in developing a training site involving many disciplines is that there are few community-based settings integrating services of two or more diverse professionals. To begin, the community setting must meet the discipline-specific requirements of each university program. For example, for pediatric and obstetrics-gynecology training, the traditional hospital setting is most familiar; for early childhood special education and regular education, the traditional classroom site is most familiar.

HEC first developed a community-based service and training setting that included clinical health, family support, and early childhood education components. That site helped students become familiar with a new, collaborative mode of service delivery. By shifting from traditional service delivery at the outset of pre-professional training, faculty avoided the problem of practitioners unlearning established modes and re-learning new ways to provide services.

The development of an interprofessional primary site piqued the interest of both pediatric and ob-gyn faculty to participate in the newly-created HRTL training. The HRTL staff tested alternative ways of integrating family-centered interprofessional collaboration. Mentoring through case conferencing and shadowing seemed best suited for cross-disciplinary learning and teaching.

The HEC/HRTL/UH collaboration over the first three years continued to raise questions: 1) How was HEC's training project successful in establishing best practices in family-centered care and collaboration? 2) How was the HRTL program integrating the service needs of families? 3) How was HRTL balancing the interprofessional service and training? HRTL sponsors were most interested in seeing the positive outcomes which the new interprofessional approach would accomplish. The sponsors used a brief program hiatus to assess the program's effectiveness. During that hiatus, HEC launched a search of community-based sites with which staff could test the training guide and replicate the practicum. In Year Four, HEC selected a more traditional classroom setting to accommodate requirements of College of Education faculty.

Year Four presented the challenge of identifying outcomes which make sustaining family-centered interprofessional collaborative training justifiable. This monograph chronicles HEC's experience of developing a partnership among several university programs and a community-based service site to train students in family-centered interprofessional collaboration.

Developmental Stages and Lessons Learned

In the first year of this effort, HEC and HRTL identified five stages in the development of a demonstration model of family-centered, community-based, interprofessional collaboration: 1) Building a shared vision; 2) Staff recruitment and development; 3) Training; 4) Monitoring, evaluation, feedback, and refinement; and 5) Dissemination.

These five stages of development include growth spurts, plateaus, and difficulties, and they vary in duration and intensity. Each stage is vital to the growth of the others; if one stage is changed, the others will be affected as well. Foremost is building a shared vision – the coming together of team members to share a collaborative vision of healthy, safe, and lifelong learning for families and communities. Critical to the shared vision is the understanding of and commitment to the family-centered collaborative mission, goals, and values. Second, team development became the focus in Year Four. Team development refers to the teams of students, faculty, and staff developing together a new generation of professionals who can collaborate effectively to achieve with families their goals, dreams, and aspirations. Third, training refers to community-based training; that is, university community-based education is highly valued, and students are encouraged to learn from the real world. Fourth, evaluation, feedback, and refinement intend to improve faculty, student, program, and family partnerships. Communicating openly, responding positively to feedback, and refining strategies together strengthen these partnerships. Finally, in the last stage, dissemination, the essence of what was learned is shared. Spreading the word about what is done and why takes many cultural forms. Families tell other families; in Hawaii, this is referred to as "talking story," a traditional Hawaiian way local people communicate. Professionals, on the other hand, primarily reach colleagues, faculty, and administrators through journals, monographs, and reports.

Zero-to-Three Hawai'i Project

Year Four brought a major shift of focus with the replication of the HEC model at two new sites in the community: Parents and Children Together (PACT) and Waipahu Elementary School. The developmental stages were adapted to the new community-based settings. New lessons emerged from each stage.

The following section will describe each developmental stage and the lessons learned in Year Four. Two basic premises were uncovered that are verified in interprofessional education literature: 1) " . . . collaboration between social work and education graduate students would promote collaboration in later services and that service collaboration would improve outcomes for children," and 2) "university preparation in collaboration would advance collaboration" (Foley, 1997).

Stage 1:
Building a Shared Vision

Lessons Learned:

- **Identify goals from the start, and clarify them regularly.**
- **Allow time to foster team commitment.**
- **Develop strategies to promote common purpose.**
- **Sustain trusting team relationships.**
- **Learn families' social and cultural beliefs and practices.**

Teaching a vision and confirming that the vision is shared isn't a one-way process; on the contrary, it's a process of engaging constituents in conversations about their lives, about their hopes and dreams.

Kouzes & Posner, 1997

Following three years of project implementation at HRTL, HEC expanded the training in Year Four by selecting two additional community-based sites, PACT and Waipahu Elementary School. PACT is an umbrella agency that administers a number of social service programs for young children and adults in Hawaii. Among their services are the Head Start and Early Head Start programs at Kuhio Park Terrace, a low-income public housing complex in Honolulu. The Early Head Start and Head Start classrooms served as the practicum sites for the students during Year Four. In addition, an integrated Department of Education (DOE) preschool special education/Head Start class at Waipahu Elementary School, located in an old plantation town outside of Honolulu, was selected as a site. These sites were chosen because they offered the students opportunities to work with families from diverse cultural and socioeconomic backgrounds, as well as with young children who have varying abilities and special needs.

Year Four proved to be an exciting challenge as HEC branched out into the community and increased its involvement with University of Hawaii (UH) departments: the College of Education (early childhood regular and special education), School of Social Work, and School of Medicine. HEC learned many lessons about the critical need to develop a shared vision among all those involved.

Lesson 1: Identify goals from the start, and clarify them regularly.

Due to the expanded number of participants in Year Four and the complex mission of the HEC project, it was imperative that all those involved understand clearly the project goals and objectives and that HEC be clear about others' goals. Prior to the fall semester, HEC staff, university faculty, and PACT staff came together to plan ways to make the practicum experience most collaborative. HEC provided faculty and PACT staff with information on the purpose and objectives of HEC. The initial meetings between HEC, faculty, and PACT were the cornerstone of the development of the students' practica. HEC and the HRTL team – with the assistance of two families – conducted a week-long training with social work and education graduate students and pediatric residents. Activities were taken from the *Training on Family-Centered Interprofessional Collaboration* (Iwaishi et al., 1998) developed in previous years. (See Appendix B for summary of the training manual.) As the semester progressed and the students became immersed in the practicum experience, faculty, students, and PACT staff addressed issues such as the role of HEC and the responsibilities of those involved. Through much discussion of project objectives, program issues, and classroom logistics, many concerns were resolved.

Lesson 2: Allow time to foster team commitment.

As with any relationship, time is an essential factor in ensuring that a collaborative team has made a shared commitment to what they hope to accomplish. It is important to consider the time involved as a vital part of team development. For many teams, addressing obstacles and challenges early is critical to effective team development. Team members learn how other members function and what perspectives they bring to the group. They also learn how to resolve best the inevitable disagreements that arise and what is most effective for coming to a decision. Since these skills can only be learned through actual team experience, enough time must be allowed to foster relationships among team members and for members to understand their own group dynamics.

Sufficient time is also essential to planning for interdisciplinary experiences. For example, while working in interdisciplinary teams is not new for the field of social work, social work faculty was challenged this year by placing practicum students in educational settings. Most schools, such as Head Start, do not employ social workers. Because master's level social work students at UH require an on-site preceptor, much time was spent looking at ways the preceptor requirement could be met in a school setting. Developing innovative interdisciplinary experiences among traditionally independent disciplines clearly requires commitment to a new vision and time to address new challenges and to build collaborative relationships.

Starting out, we thought we were doing a good job at collaboration. Then it dawned on us about three months into it that we were still doing our own things separately. One change was that we got better at communication. By the last year, we had it working very fluidly.

Wakatsuki, 1997

Lesson 3: Develop strategies to promote common purpose.

Meeting the needs of young children and their families challenges faculty to change training and practice within existing university department structures. HEC and faculty worked to reach a common purpose in two ways: 1) by developing communication in which all faculty understood each other's unique departmental barriers to involvement; and 2) by creating practica that provided collaborative service (Foley, 1997). Each university department traditionally has practica sites from which students learn their profession. For education, it is the classroom; for social work, it is the community agency; for medicine, it is the hospital or clinic. When HRTL was first targeted as a primary site, it was most suited and developed for "traditional, graduate medical education . . . a blend of training and education, of service and learning" (Roberts 1996). HEC found that this was commonplace for medicine and social work. Although the university faculty recognized that learning goes beyond the classroom, beyond the agency, and beyond the hospital, requiring students 'real world' learning (referred to as "in vivo" models of learning in HEC's Year One monograph), university department criteria needed to be met. To meet the UH College of Education criteria, HEC and the education faculty agreed that the Early Head Start and Head Start programs fulfilled the College's practicum requirement.

It is important to fully understand the barriers that faculty must overcome for full participation. In pediatrics, for example, the faculty reported that hospital administrators began questioning the financial viability of training outside the medical center. The obstacles that pediatric faculty face are paramount. At a recent conference, pediatric leaders agreed that

I believe that all collaboration begins with trust. Individuals need to feel that they are part of a team which is working toward a common goal before any work can be accomplished. The students worked well when there were clear parameters of who was to do what, who was taking the lead, who needed to be seen if there were problems, and when there was flexibility and fun built into the project.

Richard, 1998

a typical challenge is funding community-based education. Resident education is hospital-based. Clinics connected to a medical center are eligible for Medicare reimbursements; those which are not must compete with federally qualified clinics for small pots of money. "Unless a clinic is owned by a hospital, no funding is available to support outpatient or community rotations" (Osborn, 1996). Commitment to the common purpose of providing practical training that will prepare new professionals to practice in their communities in family-centered and collaborative ways is necessary to overcome such barriers.

Lesson 4: Sustain trusting team relationships.

Collaboration at all levels begins with and is sustained by mutual trust. As the graduate student in early childhood education, said, "As a team, I see a big change in the collaborative process since we began our practicum. At first, we didn't know each other, and now I can confide in them" (HEC student interview, 1998). She and the other students felt that their involvement as a team enhanced their practicum experience, and, in fact, was one of the most positive aspects of the practicum. According to the doctoral student in special education, "We knew that as a team we could face the challenges together. What would have happened if we didn't get along ?" (HEC student interview, 1998). The graduate student in social work added, "As a team, we became stronger and independent. We can take on challenges. In the beginning, I felt that everyone went into a practicum with structure except us, but now I see that provided us with a challenge" (HEC student interview, 1998).

Trust is equally important among faculty, and as the faculty team established itself, it became evident that the members felt more comfortable acknowledging commonalities and differences among disciplines. Initially, faculty were concerned about the length of the pediatric resident's one-month rotation. Because the other students (social work, early childhood education, and special education) were involved with the practicum site for an entire year, some faculty were unsure how the residents would fit with the already-established and functioning team. This provided a challenge for the students. They meticulously planned each month with the new resident and managed a complicated schedule which accommodated all of their individual schedules. Their time spent at the site needed to provide as much learning for the resident as possible; it had to be focused and rich with team and family interaction. As the faculty observed how successfully the students approached this challenge, they withdrew control and followed the students' lead. This allowed the students greater freedom to create their own collaborative learning experiences.

As trust grew and developed within individual teams, it was imperative that trust develop on an inter-team level as well. The inter-team trust served as the scaffolding to support and guide the development of trust within teams. The pediatric faculty member stated that one of the most positive aspects of the practicum was the flourishing relationship with PACT. She said, "Although it took some time, we have a relationship with this community agency that's been validated. They've given us a 'live' community classroom, and we've provided them with university students. It's a win-win situation" (Iwaishi, 1998). Sustaining mutual trust by scheduling regular meetings, clarifying logistics, and keeping close phone and personal contact nurtured strong bonds among team members.

Lesson 5: Learn families' social and cultural beliefs and practices.

Families must be part of the shared vision. Moving toward a shared vision with people of different cultures – whether ethnic, professional, or other kinds of cultures – requires continuous effort.

Currently, there is much interest among researchers and practitioners about culture as it shapes our development. The findings of their studies are becoming applicable to early childhood education and care. "Cross-cultural findings can be used to develop intervention strategies and policy positions relevant to children and families within varying cultural contexts" (Gardiner, Mutter, & Kosmitzki, 1998). Rather than assuming they know how others are thinking and overlooking "what kinds of settings, customs, and ideas characterize our children's lives" (Gardiner et al., 1998), professionals should continuously question, listen, dialogue, and share ideas with others about what is important to each individual. In fact, children themselves can teach professionals and families much about their understanding of culture. A four-year-old child expressed her experience when she explained her bilingual environment: "I thought it was all one big language, and Mommy understood some words, and you understood others, and I understood them all!" (Alisa, quoted in Gardiner et al., 1998).

Because PACT is deeply committed to understanding and integrating the cultural diversity of the families it serves, it was an ideal parent organization for the Head Start and Early Head Start programs, both of which require parent involvement in program planning and implementation. Those programs provided excellent learning examples for the student, faculty, and HEC teams during Year Four.

From the incidents of cultural competence the students experienced at PACT the teams derived the following important lessons: Understanding others' cultures is an ongoing learning process. It is okay to feel uncomfortable or unsure of how to respond when learning about families' cultures, but it is essential to be nonjudgmental. Individuals assimilate into their own cultures unconsciously, which makes teasing out assumptions about culture difficult. When considering families' cultures, it is important to see beyond labels and to recognize that individuals' unique cultural characteristics are the sum of many influences, including ethnicity, religion, socioeconomic status, professional affiliation, etc. Finally, professionals should regularly scrutinize their own practices for cultural competence. Visioning with families of different cultures expands professionals' ways of thinking and improves the services they provide.

A major challenge to pediatricians in fostering parenting is the wide range of family types present in modern America. This diversity includes major differences in marital status, sexual orientation, biological relationship to the child, parental age, racial and cultural background, and employment. . . . To be effective in dealing with parenting issues, we need to understand, respect, and support all types of families.

Howard, 1998

Stage 2:
Team Development

Lessons Learned:

- **Create collaborative environments for team leaders to emerge.**
- **Schedule team meetings on a regular basis.**
- **Keep lines of communication open.**

> **A team, to be effective in achieving its goal, must commit to a constant process of team building and developing cohesiveness.**
>
> Briggs, 1997

A major focus during Year Four was the development of the student and faculty teams. The helping professions are plagued with queries about why professionals should be involved in teams. Pediatric literature reveals the following knowledge, attitudes, and skills acquired by residents in school settings as a result of teaming (Zenni, Sectish, Martin, & Prober, 1996). Within school environments, residents may increase knowledge in normal growth and development not typically emphasized and develop attitudes that appreciate family diversity. Residents may also improve their skills as a "pediatric consultants" for parents and teachers, thus increasing their ability to convey advice sensitively. In a classroom setting, residents may have the following cross-disciplinary learning objectives:

> **Knowledge: Improved knowledge of normal child development from ages 5-14 years; familiarity with organization of school system; familiarity with principles of education for students with special needs; improved knowledge of usefulness and limitations of psychometric tests**
>
> **Attitudes: Appreciation of the role of teachers and pediatricians as "team members" in working with school health-related issues; appreciation of the impact of chronic illness on school functioning; demonstrated sensitivity to the impact of cultural differences/ bilingualism on school functioning**
>
> **Skills: Served as educational resource to teachers, students, parents; evaluated and participated in treatment of school-related problems (attention deficit disorder, learning disabilities, behavior problems); developed improved ability to communicate with children; developed improved ability to counsel parents in a sensitive manner**
>
> Zenni, Sectish, Martin, & Prober, 1996

Based on current interprofessional literature, a number of lessons have been learned. Educators in collaborative settings "emerge with greater wisdom and purpose, with a stronger support network, and with a greater sense of hopefulness, which works, one expects, to improve outcomes for children and families" (Foley, 1997). The social work literature documents the social worker's role in collaborative settings: providing the possible etiology of behavior, thereby creating a better understanding of behavior for teachers and pediatricians. Social workers enable both professions to work more effectively with the child and family. For example, the social worker can broker important information by conveying to the pediatrician that the family did not have a refrigerator for prescribed antibiotics and by conveying to the teacher that the child just experienced a week of domestic violence.

Faculty and student teams came together and established their own guidelines and procedures. Each faculty member sought to understand the history, beliefs, knowledge, and attitudes on

which the other disciplines were based. They listened respectfully, engaged in honest exchanges, and openly voiced their differing opinions about how the student team should work.

Lesson 1: Create collaborative environments for team leaders to emerge.

Effective leadership is essential to a team's success. Whether identified by the teams themselves, by HEC, or others, it is important to designate a leader to keep each team functioning effectively and to maintain communication with other teams. In the student team, a leader was identified by a faculty member based on the student's previous experience and relationship with PACT (the student had completed a prior practicum at the site) and on the student's degree program (the student was a Ph.D. candidate, and the other students were in Master's degree programs). No team leader was initially designated for the faculty team. Each of the faculty members assumed leadership in important and different ways including provision of energy, time, and direction. Because the pediatric faculty member had been a part of the HEC project for three years and had the most experience with implementing the principles of family-centered interprofessional collaboration at HRTL, she emerged as the team leader and was able to lend her expertise as Year Four started with the additional faculty. The faculty team was able to draw on her collaborative experience, and this further influenced the team's growth.

The importance of designating a team leader cannot be overstated. Decisions regarding how the leader will be chosen, how long the person will assume leadership, and the role of the leader can be determined by the teams themselves or by someone outside of the teams. Effective leadership is a critical factor in successful teaming.

Lesson 2: Schedule team meetings on a regular basis.

> **I really enjoyed going to the meetings on Fridays. It's really interesting to hear from all the different disciplines.**
>
> Wong, 1998

As part of the initial planning between HEC staff, faculty, and PACT staff, the importance of regular team meetings was agreed. It was decided that meetings would be held weekly for all those involved with the project. There were three objectives for those meetings:

1. Focus on one of the seven principles of family-centered interprofessional collaboration (distilled to collaboration, respect, cultural diversity, trust, communication, interagency coordination, and negotiation).
2. Address the following questions related to each principle:
   - What did I learn about working with families?
   - What did I learn about working with other professionals?
   - What problems did I see and how were they resolved?
   - How could/did I help?
3. Discuss any practicum questions/concerns.

The weekly meetings provided the opportunity for everyone to come together and share their experiences. All team members said in interviews that the meetings were crucial to the ongoing development of the project in a number of ways: they provided a forum for communication, they helped teams establish themselves, and they helped foster inter-team relationships. Most importantly, regular meetings provided the various disciplines with opportunities to share and to learn from one another. According to the practicum director for the School of Social Work, "Definitely, the weekly meetings were one of the best parts of the practicum. I enjoyed hearing students' experiences and also learning other discipline's thoughts. That was very positive" (Matayoshi, 1998).

In addition, the meetings also functioned as an important venue for training. Included in the training were discussions about family-centered care and interprofessional collaboration, reviews of pertinent journal articles, and an overview of each discipline's assessment practices.

Lesson 3: Keep lines of communication open.

It is widely understood that communication is one of the keys to successful collaboration. However, facilitating effective communication requires an understanding of the individuals involved and what works best for them. One of the challenges during Year Four was maintaining communication between all those involved. The students experienced some confusion initially at their practicum site, not knowing which staff to approach in specific situations. As a result, communication was not always clear, and occasionally information was not conveyed in a timely manner. At the start of the spring semester, one of the students changed to a different classroom at the practicum site. Because of miscommunication, this was not clear to the program managers. It took several weeks to determine that there was a problem, and this issue was finally resolved at a meeting in March. By keeping communication clear and timely, the situation could have been either resolved earlier or possibly avoided.

During the fall semester, the students, faculty, PACT, and HEC staff met weekly to discuss practicum experiences and opportunities for learning. During the spring semester, the students were given a greater degree of responsibility and independence, and meetings for the whole group were reduced to a monthly basis. However, due to scheduling arrangements, the weekly meetings among the students did not continue. This impacted the cohesiveness of the group and influenced what was once an effective forum for communication. From interviews conducted near the end of the semester, it was apparent how much the teams valued the weekly meetings. In fact, the weekly meetings were consistently mentioned by all those involved as one of the most positive aspects of the practicum. Team members expressed the desire to meet more often, saying that the meetings provided them with a venue for sustained communication and kept them updated with student progress and changes in program.

Stage 3: Training

This year, HEC further developed their family-centered interprofessional collaboration model by placing students from four disciplines at the PACT site. There, students from the UH John A. Burns School of Medicine (pediatrics), School of Social Work, and College of Education (special education and early childhood education) worked together in the Early Head Start and Head Start classrooms. This was the first time that students from all four disciplines participated concurrently. It provided them with the important opportunity to meet regularly and share their practicum experiences. A total of nine students (six pediatric residents, one social work student, one special education student, one early childhood student) participated in the practicum this year. Training was conducted by HEC staff, faculty, and the practicum students for PACT families and staff.

Lessons Learned:

- **Provide guided learning opportunities.**
- **Know your audience.**
- **Utilize the expertise of staff, students, and families.**
- **Distinguish between interprofessional and professional competencies.**
- **Value peer learning.**

Lesson 1: Provide guided learning opportunities.

At the start of Year Four, pediatric residents and graduate students in social work and education participated in a week-long training conducted by HEC/HRTL staff using the *Training on Family-Centered Interprofessional Collaboration* (Iwaishi et al., 1998). The training, which focused on family-centered care and was conducted by families and professionals together, included topics such as the elements of family-centered care, children with special needs, and the need for interprofessional collaboration. That training provided the foundation for the guided learning opportunities that followed during the year.

As part of the practicum, students participated in learning activities with the children in the classrooms, home visits with the families, field trips in the community, and meetings with parents. They interacted with children and families in their natural environments, which gave them insight into many facets of the families' lives. Most importantly, being together with students from other disciplines provided them with insights they would not have gained had they been in the practicum on their own.

As part of their rotation, the medical residents also participated in community site visits conducted by the other students and HEC staff. Based on the interests of each resident, the various sites included a self-contained special education preschool classroom, an integrated special education/Head Start classroom, and a community child care center. On one of the site visits, the resident recognized two of the children as former patients. This provided an opportunity for the teacher and resident to engage in discussion and for each to gain a better understanding of the children's lives.

As part of the practicum, HEC faculty, students, and PACT staff met weekly to discuss the seven principles of family-centered interprofessional collaboration. Each week, a different principle was discussed, as students related their most recent experiences with families, PACT staff, and other students. This training, included as part of each meeting, was done informally; it provided the students with a forum to explore what they had learned about family-centered interprofessional collaboration. Because of the number of people involved

Far from 'coddling' their clients, which worries conservative politicians, the new professionals aim, quite consciously, to strengthen the ability of clients, students, young people, and families to make the journey toward independence and to take greater control over their own and their children's lives.

Schorr, 1997

and the intricate nature of the project, it was essential to sustain frequent opportunities for guided learning exchanges and to adhere to a consistent principle-to-practice focus.

Lesson 2: Know Your audience.

One of the exciting developments in Year Four was the introduction of parent/staff training sessions at PACT conducted by the students. The idea for student-conducted training developed from previous parent training experiences of residents at HRTL. This was viewed as an important objective for all the students because it provided opportunities for them to connect closely with families and to collaborate with other disciplines. At PACT, the topics were chosen by the families, and the students worked collaboratively to prepare the format and to collect information for each training session. While the training sessions were facilitated by the pediatric resident, the other students had a role in development and design, making sure the content and materials were appropriate for the families. For example, as preparation for one of the parent training sessions, the special education, early childhood, and social work students worked with the pediatric resident to de-mystify some of the medical language. This led to a well-attended and successful presentation.

PACT staff expressed gratitude for having a doctor available to address issues for their families and wanted to take advantage of this opportunity by scheduling the presentations monthly. Five presentations focused on the following: Seizures, Pervasive Developmental Disorder, Skin Conditions in Children, Going to the Doctor, and Childhood Safety. These presentations provided a wealth of information to parents and PACT staff as well. A variety of media was used to conduct the presentations, including transparencies, handouts, and examples of "safe toys," and residents often provided materials (packets, notebooks, clipboards) for the parents to take home. These student-conducted training sessions enabled the students to know the families better; in turn, knowing the families made the presentations most effective.

Lesson 3: Utilize the expertise of staff, students, and families.

Listening to what families have to say is one of the most important factors in developing a new generation of physicians, social workers, and early childhood professionals working in a family-centered, interprofessional model. According to Lisa, the early childhood educator at HRTL, "We collaborated by being flexible and responding to the needs of families and other team members" (Carlson, 1997). Mel, the social worker at HRTL, added,

> **One of the most important things is to make families feel that social workers like me are really there for them. It's all about the engagement process with the families, making the families and especially the children feel welcome, and communicating to families that we're here for them to help them be the best parents they can be.**
>
> Hayase, 1997

The students also served as a valuable resource for addressing family needs. They were able to focus on families without becoming overly concerned with their discipline-specific roles. In

other words, the students were able to work with families in ways that were determined by what each family needed rather than what the students felt should be provided according to their disciplines. As two students described,

> **I think the hard part about helping families is getting parents to feel comfortable with me. Once a parent was telling me her experiences; it sounded like she just wanted to vent. She told me a lot, and all I did was listen. It was reinforcing.**
>
> HEC student interview, 1998

> **It's so important to interact with different professions. It's a learning thing – by working together, we won't contradict each other. Information will be similar, and it will be easier for the parent. I've become sensitive to how I word things, and I've really learned a lot.**
>
> HEC student interview, 1998

True competence is more about growing in wisdom than accumulating more knowledge. It entails striving toward a psychological and spiritual maturity that results in real personal power.

Peck, 1997

Lesson 4: Distinguish between interprofessional and professional competencies.

During Year Four, HEC recognized the challenges of working with faculty from diverse disciplines in preparing new training modalities with their students. Faculty usually have certain discipline-based viewpoints. Moreover, many traditionally-trained faculty and professionals still worry that interprofessional training will dilute professional competency. Understanding these specific field perspectives helped HEC see the faculty members' challenges to separate their professional competencies from the interprofessional ones.

The pediatric faculty member demonstrated openness by developing an innovative health rotation which departed from the traditional medical approach. She proposed for her residents interactive techniques taken from the other disciplines, such as guided learning from medicine and journal writing and eco-mapping drawn from social work and education.

In education, training is usually classroom-based.

> **. . . A single-discipline background can preclude any opportunity for students to have dialogue about, negotiate, and jointly develop an intervention plan with personnel from other disciplines as part of a structured supervised experience, resulting in an absence of cross-disciplinary team competence.**
>
> (Kilgo & Bruder, 1997)

The education faculty expanded their focus to include not only classroom experiences but also home visits and hospital and school site visits.

University interprofessional literature suggests that certain interprofessional competencies and complementary skills and knowledge for faculty are needed. Most of these interprofessional competencies are consistent with the themes identified by the teams during the first semester. Faculty agreed to meet with students as a group to create opportunities to be in collaborative situations with other disciplines. Finally, over the four years, HEC found that one of the most critical interprofessional skills practitioners must learn is the ability to mitigate the paradox of service:

Peer Learning

The social work student, in her first observation of an early childhood classroom, was impressed by the teacher's relationship and skill with the children. The teacher was facilitating breakfast for the children. The social work student observed the teacher encouraging the children to ask politely for the things they wanted (instead of just pointing at them). The student also noticed that the teacher wouldn't do things for the children, but would help them do for themselves (e.g., pouring milk), and the student felt that was empowering. The early childhood education student explained to her colleague that encouraging young children to ask for things helps to stimulate language development. Both students benefited from the articulation of their observations to one another.

The balance between being supportive and being challenging, between providing security and new worlds to master, between building on family strengths without forgetting that family pathology also requires a competent response, is hard to achieve and maintain.

Schorr, 1997

Lesson 5: Value peer learning.

One important distinction between the collaborative training experience at HRTL in past years and this year's practicum at PACT was student-to-student contact. At HRTL, pediatric residents and other graduate students worked with the interprofessional team, mentored by the professionals most closely aligned with the students' fields of study. At PACT, however, the students formed a high-functioning interprofessional team themselves, often learning as much from one another as from families and professionals on site. Equally, the interdisciplinary faculty team worked together, learning about each others' disciplines as the practicum progressed.

The faculty and the students identified their team growth and the opportunities to learn about other disciplines as the most positive aspects of this practicum experience. The peer contact among students allowed them to develop working relationships in the face of common challenges, such as frustration over scheduling glitches. In turn, the students' close work together allowed them to see one another as individuals and to demystify their professional roles. This was especially true of the reciprocal contact between the pediatric residents and the other students; one student described a resident as "the first doctor that really made me feel comfortable." Moreover, as they turned to one another for interprofessional guidance, the students articulated their own professional positions and understood others' positions at the same time, thereby cementing both their professional and interprofessional learning. (See Sidebar: Peer Learning.)

Another important note about peer learning is that students may be more interprofessionally-socialized than the faculty who train them. For example, among this year's practicum participants, the social work graduate student worked part-time in a fully self-contained special education setting, and the early childhood education graduate student earned her Bachelor's degree in social work. "Multiprofessional students . . . often are ahead of faculty in their thinking and work well with other disciplines and the community, bringing fewer preconceived notions with them" (Maurana & Goldenberg, 1996).

Stage 4:
Evaluation, Feedback, and Refinement

Complicating the process of choosing outcomes is our lack of experience in this country in thinking together about the substance of what we are really after.

Schorr, 1997

Interprofessional collaboration is an exciting yet complex challenge. Evaluation is critical to ensure both that project goals and objectives are being addressed and, most importantly, that children and families benefit from the work done. Due to the major focus on faculty and student team development in Year Four, HEC's evaluation shifted to become more outcomes-based.

During Year Four, Anne Duggan, Sc.D., of Johns Hopkins University conducted two evaluations, the HEC training and HRTL service evaluations. For the HEC evaluation, Dr. Duggan used student and faculty interviews and resident surveys. HEC also conducted interviews with faculty, students, HRTL staff and administration, and PACT staff and administration. Interviews focused on definitions of and barriers to interprofessional collaboration; faculty, student, and program perspectives on working with varied disciplines; and ways of sustaining the HEC interprofessional collaboration model in the future.

Lessons Learned:

- **Choose competency-based evaluation.**
- **Integrate team input in ongoing project refinement.**
- **Listen to families.**

Lesson 1: Choose competency-based evaluation.

. . . For the long-term success, programs must be accountable for their outcomes. Program evaluation has seldom been a strong, integral part of medical education.

Osborn, 1996

Competencies from the different disciplines involved at PACT served as a foundation for developing interprofessional practica. While each set of competencies had features unique to its particular discipline, the commonalties focused on developing an understanding of and appreciation for various professional roles.

Faculty developed the practica with an eye on what constitutes competency-based training and evaluation. The faculty presented each of their departments' goals and objectives. Some were performance based, and others were not. (See Appendix E for excerpts.) Performance measures are demonstrated skills by which the degree and quality of students' abilities to carry out particular objectives can be addressed. For example, one performance objective for medical residents is to develop the ability to investigate community-based resources. A performance measure for this rotation is the resident's ability to apply this information to eventual office practice, i.e., good, fair, or poor resource referral.

The second part of competency-based evaluation is data collection and assessment. The pediatric faculty member required the residents to assemble a binder of materials collected from different programs they visited during their community health rotation. In addition, she

The single obstacle to realizing the benefits of shifting to results-based accountability is the lack of reliable information about the connections among intervention, interim milestones, and long-term outcomes.

Schorr, 1997

reviewed journals reflecting the residents' rotations to determine the tone and extent of the residents' learning experiences.

In addition, although the pediatric faculty member expressed preference for using "real family" studies, circumstances pre-empted the use of this real-world learning technique. The next best technique, then, was to develop a "hypothetical family" study with which the resident could apply data, make assessments, and determine appropriate treatment. The residents were then evaluated on the strengths of their preliminary analyses, selection of materials, and explanation of the materials' usefulness. Learning outcomes such as the ability to delineate the procedure for accessing a particular community service can be used to assess the residents' learning (Roberts, 1996).

In order to evaluate successfully a competency-based training program, Osborn recommends that, "Those responsible for program development and implementation must have the authority to make operational decisions; they must have adequate financial resources for program support; and they must be accountable for program outcomes" (Osborn, 1996).

Lesson 2: Integrate team input in ongoing project refinement.

Due to the increased number of faculty and students involved with HEC in Year Four, it was important to elicit feedback conscientiously from all team members. Lively accounts of the student team's weekly experiences intrigued faculty, PACT staff, and HEC staff. At regular meetings, the students queried the faculty about program incongruities and inconsistencies. As mentors, the faculty posed thoughtful questions which normalized their expectations of program realities for students, PACT staff, and HEC staff alike. PACT staff welcomed the students' perspective on the interactions between staff, children, and families at the site.

HEC gathered data rich in critical incidents which can be cycled back and applied to the next practice encounter. The data from two semesters of tested practice indicated three outcomes: 1) the process was satisfying to faculty, students, and site staff; 2) the entities involved worked fairly well to create the interprofessional practica; and 3) the goals of the interprofessional practicum and the site were implicitly congruent with the interprofessional learning goals. The most valued aspect of the interprofessional learning was the intensity and frequency of their interactions. Foley's nine-university study on interprofessional education includes an account which is uncanny in its similarity to this year's interprofessional practicum:

> **The most intensive demands for collaboration were made on faculty leading joint internship experiences. Faculty were called on to meet regularly, sometimes weekly, to plan and manage joint service activities, to provide training and supervision to graduate students, and to orient and maintain contact with [site] staff participating in the initiative. The time demands were costly and the interpersonal demands stressful. Professional paradigms and individual personalities were not easily meshed.**
>
> Foley, 1997

When evaluating collaboration, then, an assessment should include "an examination of how smoothly the different entities worked together and to what extent cultures, goals, and interests are congruent" (Horsch, 1997). The most convincing evidence of a successful practicum at PACT was that students and faculty recommended the continuation of the collaborative practica in the fall semester, beyond HEC project support.

Lesson 3: Listen to families.

HEC, students, and faculty worked with the program to involve families. PACT staff were a liaison between families and the other practicum partners. PACT staff helped identify the topics in which parents were most interested for student presentations.

Emerging from the pediatrics literature is support for the importance of listening to parents regarding non-medical concerns. Studies have validated the need for pediatricians to respond better to parents who ask more questions about child development and behavioral concerns. In a recent study, findings indicate that "the interventions of pediatric clinicians can positively affect parental behavior" (Young, Davis, Schoen, & Parker, 1998).

Horsch also advises that though collaboration usually focuses on the relationships among agencies, "parent and family involvement is also an important component of collaboration." Horsch recommends for teacher preparation,

> **If we are to adequately prepare teachers to involve families, they must develop a national network to support teacher preparation in family involvement, evaluate the experiences and outcomes for preparing teachers to work with families, make family involvement training available to elementary, middle, and high school teachers, and improve the effectiveness of training through collaboration across subspecialties and disciplines to include disciplines in the fields of health and social services.**
>
> Horsch, 1997

The new practitioner, then, especially in working with populations that have been disconnected from the supports traditionally provided by families and neighbors, is able to help reduce dependency and strengthen families by adopting a new, empowering, and collaborative mode of professional practice.

Schorr, 1997

Stage 5: Dissemination

Lessons Learned:

- **Communicate outcomes to families, communities, and training institutions.**
- **Produce useable, high-impact collaborative materials.**

Spreading the word about a new practice takes different forms with families, colleagues, students, faculty, and administrators. At the grassroots level, families tell other families about their successes and problems with a new mode of services. Students share with other students about their innovative Master's programs and their challenges. Colleagues, faculty, and administrators publish in journals, monographs, and reports. Project staff publish and present their findings in public arenas – through conferences, training, and technical assistance – to convey innovations for continued financial support.

Lesson 1 : Communicate outcomes to families, communities, and training institutions.

> **Local communities, agencies, and programs struggling to reform their services or rebuild neighborhoods are clamoring for interim outcome indicators.**
>
> Schorr, 1997

"I wish those providers would get their act together before they talked to me," exclaimed a parent in a planning meeting for the National Commission on Leadership in Interprofessional Education Conference in 1997. This typifies parental feelings about providers. For this reason, HEC made a more direct impact on the students, faculty, university, and community providers and a less direct impact on families. HEC was able to gain the cooperation of three community-based sites (HRTL, PACT, Waipahu Elementary) and, indirectly, of other local communities (Koolauloa, Ewa, Hilo/Puna).

Two of the three sites were satisfied and expressed continued interest in the interprofessional collaborative practica for fall of 1998. Pediatric, social work, and education faculty also believed that the practicum experience for their students was valuable. These intermediary outcomes must be shared with others in communities and university departments. Spreading the word of a successful training model stimulates interest and willingness to try. Replicating and sustaining family-centered interprofessional models like these require intensive, thoughtful strategies; dissemination is the first step toward replicating and sustaining a successful program.

HEC presented to national audiences in conferences and invited nationally-recognized speakers to Hawaii, locally creating excitement and interest about the need for interprofessional collaboration and service integration. HEC has witnessed continued interest in family and interprofessional collaboration initiatives. The findings from this project will be useful to other projects that are not only building bridges within, but also building bridges out.

Lesson 2 : Produce useable, high-impact collaborative materials.

During the past four years, HEC used different media to disseminate the conceptual model of family-centered interprofessional collaboration. Since 1994, over 3,400 monographs in the *Building Bridges* series have been disseminated to prominent leaders and national audiences including the Education Resource Information Clearinghouse (ERIC), Southeastern Institute for Faculty Training, Carnegie Corporation Starting Points Initiative, American Academy of Pediatrics, National Association of Social Workers, National Association for the Education of Young Children, and the networks of the National Commission on Leadership in Interprofessional Education. Also, HEC's *Training on Family-Centered Interprofessional Collaboration* manual has been eagerly sought by pediatric training programs across the country as a new curriculum to accompany the increase in community-based training for pediatric residents.

What's important is what the vision does, not what it says.

Senge, 1995

Zero-to-Three Hawai'i Project

Sustainability

As this four-year project ends, questions for sustainability arise. There are no simple answers. Questions of why and what should be sustained may be answered by revisiting the project goals. HEC attempted to identify, use, and preserve the new ways in which families are viewed and in which professionals work together to help families. Families were encouraged to see themselves as capable of making the best decisions for themselves and for their children. Professionals learned to work from their disciplines and from a broader context to include other disciplines in health, social work, and education.

Literature and practice in human services have become dense and complex. Even within each arena, fields have divided and subdivided so much that a myopic view of the family has been created. Yet disciplines have become specialized for a purpose – the knowledge and skills in certain areas have increased exponentially. Medicine, for example, has evolved from health to medicine (e.g., family practice) to medical specialties (e.g., pediatrics) and subspecialties (e.g., pediatric neurology). On one hand, it is important not to lose sight of the advances science and technology have made in these subspecialties. On the other hand, it is essential that families and professionals see the whole picture.

The magnitude of sustaining demonstration models remains hidden or is blatantly ignored. Successful demonstrations, once proven effective, are challenged to replicate their models in other neighborhoods, communities, and states. As Schorr affirms regarding the replication of many "hot house" models, "We didn't realize that people-centered intervention can't be turned out like widgets" (Schorr, 1997). The family-centered interprofessional collaboration training model, the HEC personnel preparation approach, was equally tested first for its replicability in other community-based sites then for its sustainability within the University of Hawaii (UH).

The six elements of successful replication (Schorr, 1997) frame HEC's Year Four experience. The first element was adapted by "tak[ing] the essence of the work" (Schorr, 1997) and asking faculty and students to adopt it in a practicum. HEC introduced the principles of family-centered interprofessional collaboration as a guide for faculty, students, and PACT staff to work in new ways together. They were asked to consider the principles as they worked as teams and with families. In the two semesters that followed, HEC staff documented how these principles were considered by the students, faculty, and staff. HEC's notes became the process record of the interprofessional teaming experience. The data enabled HEC to compare the teaming experiences from the professionals at the HRTL site to those of the students and faculty at PACT.

The second element of successful replication is the "continuous backing of an intermediary organization" (Schorr, 1997). For HEC, the backing of the UH faculty who "offered to the collaboration expertise, outside support, legitimization, and clout to help sustain the scaled up intervention" legitimized HEC's work at PACT. In the case of the HRTL collaborative, the sponsors recognized HMA as the initial intermediary organization. However, as soon as CFS

took leadership as the intermediary organization, their support of HRTL service and training was in question. National evaluators have noted that continuous support of current sustainable collaboratives depends on four factors:

- **the satisfaction of beneficiaries that their own needs are being met;**
- **the belief of beneficiaries that the program is "making a difference;"**
- **the degree of controversy related to the program; and**
- **the confidence of stakeholders that the use of scarce resources for this purpose is justified relative to other potential uses.**

Horsch, 1997

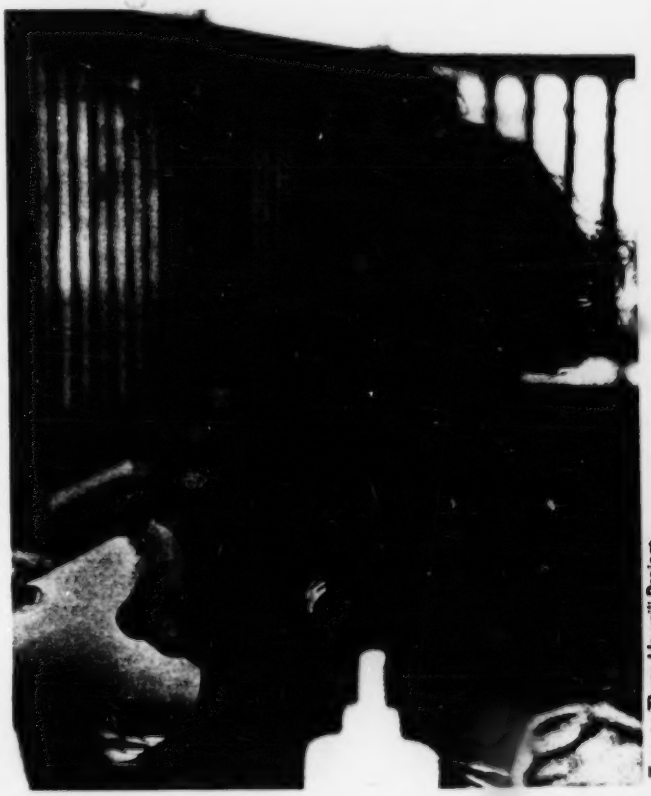
HEC found that HRTL constituencies did not believe that beneficiaries' needs were being met or that the program was making a difference. HRTL was plagued by the high degree of controversy around it, and it suffered from a lack of stakeholder confidence that use of resources was justified. These indicators led to the hiatus of the HRTL service and training as it was originally conceived for re-evaluation.

This action gave HEC the opportunity to adapt its training to another community-based site (PACT) and to institutionalize the interprofessional values, knowledge, and competencies in professional course work at UH. Unlike HRTL, PACT offered university faculty a classroom site, which was highly desirable for the College of Education faculty. The education faculty agreed to join the pediatric and social work faculty, who had already been working with HEC, by placing students in PACT's Early Head Start and Head Start programs. Strong support from the Deans of the UH Schools of Medicine and Social Work and the administration of PACT made it possible for this collaborative training agenda to progress.

The third element of replication is recognizing "the importance of the systems and institutional context" in order to place scaled up efforts in the mainstream of public funding (Schorr, 1997). This connection is supported by the pediatric literature.

> **Unless the overall environment of the [medical] school or the [residency] program will support growth and innovation, the implementation will be frustrating and perhaps even impossible. Success will depend on two factors: 1) leadership, and 2) an organizational structure that aligns responsibility, authority, resources, and accountability.**
>
> Osborn, 1996

HEC pursued the eventual integration of the family-centered interprofessional training into interested university programs as the final outcome of the project.



Zero-to-Three Hawai'i Project

They found that the faculty were sparked by the innovation and frustrated by the problems of time and discipline-based tension in equal measure during implementation. Despite some reservations, the faculty intend to continue their collaboration beyond the HEC Project.

The fourth element of replication is to "recognize the importance of the people context" (Schorr, 1997), valuing individuals who believe in a collaborative approach and who persist through the highs and lows of being on the "cutting edge" of practice. Evidence from evaluations of collaborative models indicate that individuals are most important to sustainability. At HEC, if it were not for the committed faculty, with or without compensation, this effort may have ceased; the faculty were instrumental in keeping even the most fragile of relationships alive.

Public demand for effective and efficient programs lends itself to the fifth element, "Use an outcomes orientation to judge success" (Schorr, 1997). HEC recognized late in Year Three that the HRTL service experience was not clearly documented as outcomes-based. The CFS administration took immediate action to redesign services to be more outcomes accountable. This change disrupted service; adopting an outcomes orientation from the beginning would have been more efficient. At the PACT site, the Early Head Start program standards are clearly stated. The UH/HEC training outcomes have evolved from the two-semester trial:

The sixth element of replication is to "tackle, directly and strategically, the obstacles to large-scale change" (Schorr, 1997). The pursuit of idealistic goals in the face of current reality is a rocky climb for faculty within the university institution. The reluctance of the faculty to continue with the collaborations is self-evident and understandable. As Schorr eloquently describes,

> **Demonstrations do not make waves. Moving them into mainstream systems does. Moving demonstrations into mainstream requires, to use T.S. Eliot's words, a willingness to "disturb the universe," because it means breaking the hidden ceiling on scale by changing the legislative, funding, and regulatory foundations on which the replications are expected to operate.**
>
> Schorr, 1997

The strong commitment of faculty will either break the "hidden ceiling on scale made up of a series of elaborate rationalizations that keep us from acting" (Schorr, 1997) or succumb to the towering bureaucracy that allows little leverage to university "rock climbers."

Implications for Future Interprofessional Collaboration Efforts

HEC was funded as a four-year demonstration project. Its training provided a new approach for professionals serving young children at risk, their families, and communities. It also served as a proving ground for family-centered interprofessional collaboration. The lessons learned during this period provide valuable mileposts and advice for present and future collaborative efforts. Implications include

- The value of ongoing direction offered by the original five stages in the development of the HRTL model: building a shared vision; staff recruitment and development; training; monitoring, evaluation, feedback, and refinement; and dissemination. These were identified, clarified, integrated, re-negotiated, and modified over the four years of the project as they continued to offer guidelines for work.
- Appreciation of the complexity and potential of the family-centered interprofessional model. While challenging, at the end of four years, most participants agree that the model has tremendous potential for providing more and better services to young children at risk and their families.
- Increased understanding of developmental needs of children at risk and their families.
- Means for identifying a collaborative vision, agreeing on a mission statement, and establishing clear goals to achieve them both.
- Suggestions for partnerships among service agencies.
- Appreciation of the important roles that needs assessments, evaluation, and impact analysis play in collaborative programs. Tools for evaluation are continually developing, and future programs will probably become more outcomes-based.
- Awareness of the need for the professional development of staff as they learn to serve as mentors for interns, students, and other professionals working in collaborative settings.
- Emphasis on the importance of empowerment for parents as they make decisions and learn additional skills for raising their families.

Service

- Provide a model of integrated services, such as offered at the HRTL Center.
- Further develop the co-location of services based on the medical home (AAP, 1992).
- Develop culturally competent practice. Continue efforts to build a shared vision with families from diverse backgrounds. Shared vision includes agreement on the importance of development during the early years and understanding of parenting and care practices to guide, protect, and nurture that development.
- Work with families based on their strengths as well as their needs.
- Listen to and learn from families. Parents may wish to learn from each other, and a mutuality emerges as staff learn from parents.

Training

- Develop training manuals and products for work with university students from disciplines including early childhood regular and special education, social work, and medicine.
- Develop ways to socialize and train university faculty regarding protocol, standards, and practices from other disciplines.
- Develop sustainability by identifying ongoing need and justification for good practice and approved service through the use of accountability measures. Share results of evaluation efforts with families, community, and other professionals. Include students and interns in evaluation efforts, and train in the development and use of accountability measures.
- The guided training of future professionals in family-centered interprofessional practice will help provide sustainability for the model.

Community Outreach

- Establish partnerships with families and community members through needs assessments, focus groups, parent advisory meetings, resident interviews, and community policy planning such as neighborhood watches or legislator open houses.
- Develop leadership among interested community members, and involve leaders of community groups such as other agencies, schools, churches, and policy makers.
- Encourage staff and family outreach since communities value ideas of their own members.

Dissemination

- As mentioned in Year Three, "Build a shared conceptual model which involves . . . commitment to policy, an articulation of the importance of early childhood education and the medical home, to evaluation and to the constant evolution of programs responding to individual and community self-identified needs."
- Develop instruments for outreach such as newsletters, web sites, bulletin boards, and displays at shopping centers.
- Encourage staff, administration, researchers, university host faculty, parents, and funding partners to provide leadership in the dissemination of ongoing goals, research and research findings, and lessons learned from the valuable work done.
- Develop trust and continuously work at communication, problem-solving, and shared commitment to the goals of best practice with young children and their families.

Family-centered interprofessional collaboration is an evolutionary process. The lessons learned through this four-year demonstration project are being adapted and used in programs such as the Child and Family Service HRTL in Ewa, the Kalihi Parents and Children Together Program, and Na Lei Malama in Koolauloa (a consortium of education and health providers). Several programs such as the Honolulu Community Action Program and Waipahu Elementary School have expressed interest in working together. Faculty and staff in graduate and undergraduate programs at the UH Manoa and the UH Community Colleges system have also expressed interest in future collaboration.

Learning Examples of Family-Centered Interprofessional Collaboration

This year, the students were immersed in environments rich with opportunities for learning developmentally appropriate practice and strategies for family involvement and support at PACT's Early Head Start (EHS) and Head Start (HS) programs. Consequently, their observations and experiences relate not only to working with the diverse student, faculty, and PACT teams, but also to working closely with families who have young children.

The following examples of student learning are taken from regular meetings attended by the students, faculty, HEC staff, and PACT staff. During the first semester, students were asked each week to focus on a particular concept drawn from the principles of family-centered interprofessional collaboration and to report their observations and experiences related to that concept. Topics identified were: commitment to collaboration, respect, cultural diversity, trust, communication, interagency coordination, and negotiation. Students answered four questions weekly:

- What did you learn about working with families?
- What did you learn about working with other professionals? or What did you learn from other professionals?
- What problems did you see, and how were they resolved? and
- How could/did you help?

In addition to sharing written responses to these questions, the students discussed their answers and experiences related to the identified topics with faculty and HEC and PACT staff at the weekly meetings, which HEC recorded. The following examples of teachable moments identified by the students include dialogue directed by faculty, quotes from the students, and descriptions of incidents of learning.

Zero-to-Three Hawai'i Project

(Names of children and families in the following examples have been changed.)

Principle #1:

Family-centered interprofessional collaboration promotes a relationship in which family members and professionals work together to ensure interagency coordination to provide improved services for the child and family.

Most pediatric residents (like many community pediatricians) experienced considerable "service confusion" at the outset of their community health rotations. One goal of their rotations was to learn what services are available in the community, for whom they are available, how they work with families, and how to access them. To that end, as part of their partnership with the student team at PACT, the residents visited programs serving young children including EHS and HS, a fully self-contained early childhood special education classroom, and an integrated Department of Education/HS classroom. In those settings, the residents participated with the children, their families, and related service personnel. Through these collaborative experiences, residents identified the need for interagency coordination.

Specifically, several residents visited a fully self-contained preschool special education classroom at Jefferson Elementary School called "Jefferson Orthopedic Unit." There, two residents interacted with Kimo and Alana, children whom they knew from recent hospitalizations. They helped with feeding and played with the children. Both residents remarked that it was valuable to see Kimo and Alana in an educational setting, to experience part of their daily routines, and to know them in their more natural environments. In addition, conversations with the teacher proved extremely helpful for the professionals involved. The teacher appreciated the opportunities to ask the residents about Kimo's and Alana's health status and hospitalizations. All of the professionals recognized the dimension their collaboration added to their understanding of the children and to their ability to work with them and their families in the future.

One resident, as part of her community health rotation, provided a reciprocal site visit to Kapiolani Medical Center for Women and Children for her student teammates. The resident was on-call in the pediatric intensive care unit (PICU). The other students described the experience as "eye-opening" and emotionally charged, very different from interacting with children and families in the school environment. They made the connection between those children with special health care needs and many children they see in special education programs, and they reflected on parents' feelings about their children. One student wondered, "How do parents deal with knowing that their child may not get up?" Seeing the PICU helped the students understand better the family's experience in the hospital and the resident's perception of the families she serves.

As Dr. Louise Iwaishi, lead pediatric faculty, remarked, "It can be difficult for services in the community (e.g., schools) to support children with special needs because they get sick often. An understanding of their medical situations is helpful." Although the students spent their time working interprofessionally with families within PACT's programs, they recognized the value of coordination among agencies working with families. They saw clearly that each setting creates a snapshot of the families they serve, and that interagency coordination is crucial to a more holistic perspective. At the end of their internships at PACT, the student team envisioned a future of working with families to create comprehensive health, education, and social support.

From their first experiences with families and staff at PACT and with one another, the students acknowledged the value of the diverse expertise that individuals bring to their work. As reported in both weekly meetings and student journals, the students recognized the relationships among specific staff and family members and how respect among them is essential. They saw the necessity of team work when working toward a common goal. The following experience is an early example of their observations.

Principle #2:

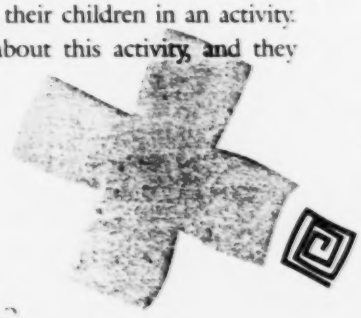
Family-centered interprofessional collaboration recognizes and respects the knowledge, skills, and experience that families and professionals from all disciplines bring to the relationship.

At PACT's Health Fair early in the Fall semester, the special education student and the social work student assisted a Parent Child Educator (PCE) with vision screening for the children. The three of them worked as a team with parents and children to complete the screening. The PCE, who was most familiar with the children and families, was the first point of contact at the vision screening booth. Some children were anxious about the screening test, so the PCE talked to the children and worked to get them relaxed, making the screening a game. The social work student suggested that the parents hold the picture cards (screening tools) at the appropriate distance so that the children could be comforted by looking at their parents while they completed the screening. The special education student asked prompting questions to help the children respond to picture cards. The team gave the children hand stamps as incentives for participating. All of them worked together to create a fun, comfortable interaction with the families.

At the time of the Health Fair, the students were just beginning to know and to define their roles with families in the program. The special education student, in particular, was concerned about some parents' discipline measures she observed which she thought were inappropriate (e.g., hitting, name-calling). For example, one father was adamant that his son take and pass the screening and seemed angry when the boy was anxious and didn't perform. The students wanted to reinforce that the screening was not a competition and that if the child was frightened, he could wait and come back later. However, they did not know the family and therefore felt it would be inappropriate to address the issue with the father.

During debriefing with the faculty, the students questioned when they should intervene, how to best support the parent, and what would be their role in that situation. They acknowledged that respect is vital to both parents' and professionals' appreciation of each other and comfort in working together, and it simply takes understanding to build respectful relationships. It can be difficult to accept families' style of discipline while upholding professional tenets (such as advocating against physical punishment). At the same time, it is essential to refrain from judging families and how they choose to raise their children.

This experience gave the students an opportunity to experience teamwork, to create child-centered activities, and to engage professionals and families and their children in an activity. They were thoughtful and respectful of the families' feelings about this activity, and they valued the knowledge of their collaborative team.



Principle #3:

Family-centered interprofessional collaboration acknowledges that the development of trust is an integral part of the collaborative relationship.

This principle was the core of the students' learning experiences at PACT from which all other principles and interactions seemed to flow. Among different kinds of students and professionals, with families, and between the levels of program administration, trust is essential for all aspects of collaboration – negotiation, open communication, commitment, and the very relationships that are the basis of family-centered interprofessional collaboration. From the outset, the students identified moments of trust and steps in its development with families and professionals at PACT.

The students were acutely aware of 1) the many levels of trust families and professionals must achieve to collaborate and 2) the necessary expenditure of time for building trusting relationships. The social work student's program-specific requirements included establishing a relationship with a particular family to understand their strengths and challenges. The student's supervisor, JoJo, helped her get parental consent to work with a particular family in whom she was interested (based on the student's work with the children in a classroom). The family allowed the student to look into their file, to interview them, and to work with them directly. A faculty member commented on the development of this kind of openness between families and professionals.

> **It takes a long time to develop trust with a family. It is good to have someone (like JoJo) whom the family trusts to facilitate introductions and to jump start the process of building trust. The student could also ask JoJo about any family sensitivities.**
>
> Iwaishi, 1998

PACT's EHS program is young – just one year old now. Watching its development, the students understood that trusting, collaborative relationships are the foundation of working with families. For example, at PACT's EHS program, parents allow the PCEs into their homes, and families and PCEs need to build trust quickly so parents feel comfortable leaving their children at the program. Because the children associate the students with their PCEs, with whom the children have relationships, the children accept the students. Parents, on the other hand, know that the students are not familiar with their children, and they tend to be more wary. But time, consistency, and care among all participants – PCEs, program managers, students, parents, and children – ultimately lead to trusting relationships, which pave the way for family-professional collaboration.

With families and colleagues, effective communication requires diligence and sensitivity. The students identified many facets of family-centered and interprofessional communication and many factors which influence their interactions with others.

Principle #4:

Family-centered interprofessional collaboration facilitates open communication so that families and professionals feel free to express themselves.

Atmosphere is a crucial element of communication with families. On an excursion to the park, one student's interactions with families were qualitatively different (e.g., more open and relaxed) than in the classroom. In the classroom, the student felt that she initiated most dialogue with families; in the park, she played with the children, and their parents joined her. She bonded with the families around their children in that atmosphere.

One pediatric resident was excited about the opportunity to become acquainted with families in an educational setting and to learn from other professionals strategies for engaging families. In practice, because of the busy clinic or office setting, pediatricians must try to develop rapport with families within a 15-minute office visit. In the safe atmosphere of the program, the resident was concerned about intruding upon families, but she found the parents to be very approachable. Following the PCE's lead, the resident began discussion with parents on common ground (e.g., talking about their child's cold or asking who is the family's pediatrician).

Another student interacted with John, a child with autism who did not use spoken language, in the classroom. To communicate with him, the student had to watch his expressions and read his nonverbal cues. At one point, John, making noise, grabbed the student's hand and took her to a table. It was obvious to the student that John wanted something, but she did not know what. His regular teacher recognized that John wanted juice. The student realized that it takes time and familiarity to build good communication with children who are just learning to use oral language.

In addition, the faculty instructed the students as follows about communication issues they should attend to during their practica:

- **Listen actively during family-centered interviewing: What kinds of questions elicit the answers professionals need to provide better services? What kinds of resources do families want?**
- **Remember that language is very important in collaboration; look for ways to develop common language among professionals.**
- **Regarding confidentiality, ask families early if they are comfortable talking with you. Work with PACT staff to understand their confidentiality policy.**
- **Use "people first" language.**

All of these are critical moments or aspects of connection among families and professionals. Each incident of open communication lays groundwork for the trust which is essential to collaborative relationships. The students were sensitive to the importance of communication, examining the nuances of successful interactions, no matter how brief, with families and professionals.

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Principle #5:

Family-centered interprofessional collaboration creates an atmosphere in which the cultural traditions, values, and diversity of families and professionals are acknowledged and honored.

The students observed that the staff at PACT are culturally diverse (e.g., Chinese, Filipino, Hawaiian, and Japanese) and that they work together well. Communication between PCEs and families seems comfortable, even when they are from different cultures.

The EHS program acknowledges the cultures of participating families. Its Family Handbook includes letters of welcome translated into Samoan, Ilocano, Tagalog, Chinese, and Laotian, and staff will arrange for interpreters if families need help understanding program services. Families are encouraged to speak in and to teach their children their native languages, but not at the exclusion of other families. They are asked to speak English in the classroom or to translate what they say in their native languages to English so others can understand the conversation.

One student observed a classroom in which three of the four families present spoke Samoan; the other family seemed to feel "left out." The PCE reminded the Samoan families about the EHS policy on using English in the classroom so all families can converse. The PCE approached the parents speaking Samoan individually and explained the policy and its purpose; in this way, she respected the individuals and their cultures. One of the Samoan parents asked a Hawaiian mother how to say certain words in Hawaiian. That dialogue among families culminated in the suggestion that items in the classroom be labeled in different languages.

In another informal conversation during an EHS activity, a mother asked the pediatric resident if it was okay to teach her daughter Samoan and English; she was afraid that her daughter was falling behind in language development. The mother explained to the resident that she knows her child needs to learn English, but she wants her child to be bilingual and to share her culture, too. The resident offered to raise the question with a speech pathologist. The speech pathologist indicated that children taught bilingually sometimes are slightly delayed in both languages when assessed early, but they usually catch up. Also, assessment can be difficult in bilingual families; ideally, assessment tools should be culturally appropriate.

The richness of ethnic and professional culture in the EHS program clearly impacts students and families. The students are able to experience cultural differences and to learn cultural competence. Families can call upon the diverse expertise of the students and residents and their supporting faculty to get answers to their questions. All learn to honor each other as individuals working within specific roles.

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Principle #6:

Family-centered interprofessional collaboration recognizes that negotiation is essential in a collaborative relationship.

Initially, when examining how the principles of family-centered interprofessional collaboration applied to practice at PACT, one student felt uncomfortable with the term "negotiation" applied to interactions between families and professionals. To her, "negotiation" implied imbalance and inequality. The faculty team addressed the student's concerns with the following questions and comments:

- **Does negotiation imply conflict? In interprofessional collaboration, negotiation does imply that differing professional standpoints exist and that each participant must determine how much s/he is going to give and take.**
- **The term "negotiation" as used in the principles comes from early intervention. Groups like Family Voices* first used the term in their "advocacy mode." Parents of children with special needs were advocating to be seen as equal partners with professionals; they had to fight for that recognition.**
- **If we are truly practicing family-centered care, do we still need to negotiate? When teachers are "stuck" on a problem, do they consider what is in the best interests of the child, the school, or the family? Perhaps it is the focus on the professionally-identified needs of the child – rather than on family-identified needs – that creates the need for negotiation.**
- **The more you interface with active parents, the more you will hear them say that professionals patronize them. It humbles you. It is difficult to be really family-centered. We all have pre-set values and priorities; if another professional or family member doesn't agree with yours, you may need to negotiate. And many skills are required for negotiation.**
- **Working with families does require give and take. We have to deal with family wants and needs and to do our best to accommodate them.**
- **As professionals, we need to be advocates for families. Often we will align with them to negotiate with others. Working with parents grounds you.**

* Family Voices is "a national grassroots network of families and friends speaking on behalf of our children with special health care needs" (Family Voices, 1998).

Principle #7:

Family-centered interprofessional collaboration brings to collaborative relationships the mutual commitment of families, professionals, and communities to meet the needs of children and their families through a shared vision of how things could be different and better.

Inclusion of children with special needs in regular education environments is a paradigm of collaboration that special education and early childhood education can offer to other professions. Inclusion requires the commitment of parents and children, teachers, physicians, and others trying to maximize the capacity of children with special needs and their families. All the students at PACT were exposed to the contrast between inclusion classrooms and fully self-contained classrooms in site visits to integrated DOE/HS classrooms and programs like the Jefferson Orthopedic Unit (mentioned in Learning Example #1).

The social work student in particular was excited about the interaction between the teachers and their students (about 1/3 of whom were children with special needs) and among the teachers themselves (a HS teacher, a DOE special education teacher, and two assistants) in the integrated classroom. First, she realized that in the "least restrictive" atmosphere of the classroom, some of the children's special needs were apparent, but others were not. All of the children had specific responsibilities in the classroom (e.g., table monitor, toothbrush monitor). The teachers used creative, stimulating techniques and demonstrated very effective partnership. All the staff worked at the same level; everyone could easily interchange roles and work with all the children (typically developing or children with special needs), who were all "our kids." The student recognized that the child-centered, collaborative atmosphere magnified everyone's potential, and that successful inclusion requires staff to put aside status considerations and to work as equal team members.

In experiencing fully self-contained settings, students were asked to envision what the children might be doing in an inclusion classroom. What would be different about the children's activity level or their interactions with their peers? One pediatric resident, working with a medically-involved child, Jenny, in the fully self-contained classroom, said that Jenny could not be educated in a regular classroom because she required too much care (e.g., Jenny was tube-fed, confined to a wheelchair, and unable to toilet herself). Lynn Yamashita, HEC Training Coordinator, challenged some of the resident's assumptions. Jenny was responsive – she smiled and interacted with the resident. Why couldn't she be cared for in a regular classroom? Why couldn't Jenny, with the right support, benefit from a lively early childhood classroom full of her peers? Lynn worked with the resident to identify system issues – such as lack of resources and supports or the attitudes of teachers – that inhibit inclusion for children with special needs.

Dr. Linda McCormick, the special education faculty member, explained that inclusion is an important issue in special education. For example, some parents of children who have special needs related to speech feel their children do not get enough language exposure in fully self-contained classrooms. Socialization is a very important facet of education. Some children with special needs are bused to fully self-contained classrooms, particularly if they have physical impairments, because therapists are there. However, parents should be able to receive services for their children in their community schools. Educational staff may persuade parents that the staff do not know how to deal with children with special needs and that those children would be better off in self-contained settings. Knowing about different settings helps professionals supporting families who have children with special needs to advocate with parents for finding niches for children that make their outcomes optimal. Together, committed families and professionals can form formidable advocacy teams to improve services in their communities.

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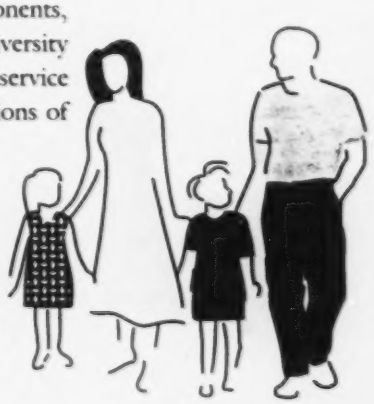
Summary

This year, 1998, concludes the Health and Education Collaboration (HEC) project, an innovative four-year demonstration. Each of the four project years represented facets of a complex model of support for building shared commitment, developing collaborative efforts, and disseminating information to improve outcomes for young children at risk and their families. The first year was a learning and development year. The second year was a year of partnerships, as professionals learned to implement their work together with families to assure positive growth and well-being for children. The third year represented progression as project staff evaluated and refined their work as an interprofessional team. Families became more clear about what they wanted and needed from the program. This, the fourth year, was a year of transition as new administrative partnerships emerged. Child and Family Services assumed operation of the Healthy and Ready to Learn Center. Other elements, such as the writing of training curriculum and the HEC *Building Bridges* monographs, continued through the efforts of the Hawaii Medical Association.

During Year Four, the sustainability of family-centered interprofessional collaboration was assured through the efforts of this demonstration model. The evolution of the model continued through the development of staff and student training. Dissemination (through the "ripple out effect") emerged as programs such as Early Head Start/PACT began to implement the family-centered interprofessional model. Other programs have also indicated interest in the model. The research and theory aspects of the model have also been successful. This year, the brochure describing the *Training on Family-Centered Interprofessional Collaboration* curriculum was distributed to over 500 pediatric residency programs and continuity clinics; as a result, more than 30 pediatric training programs have purchased HEC's manual.

Although this is the final year of HEC as originally funded, collaborative efforts will continue, and more changes lie ahead. Interprofessional collaboration is a complex process. The project's developmental stages have proven valuable. The lessons learned from each of the four years can serve to assist new programs. Valuable service to young children at risk and their families has been offered for four years. Training and dissemination components, through materials and curriculum development, are being distributed and used in university programs. Emergent forms of the collaborative process, particularly the university-service centers partnerships and the training of new professionals, will be sustained contributions of this project.

Family-centered collaborations have been achieved at many interprofessional levels, between staff and families; between service providers and university faculty and students; between funding partners and agency administrators; between trainers and researchers. The valuable lessons learned from HEC are already serving – and will continue to help – present and future professionals and families with young children and the communities in which we all live.



Appendix A:
Updates on MCHB Demonstration Projects

National Commission on Leadership in Interprofessional Education (NCLIE)

The NCLIE was initiated in the Fall of 1992 and sponsored for its first three years by the Association of Teacher Educators. Its purpose is to shape a national agenda that will make coordinated, family-centered, community-based, culturally competent services a reality. The NCLIE works to develop the capacity of future leaders in education, health, and human services to view working with families from an interprofessional perspective. Representatives from social work, public health, law, criminal justice, psychology, medicine, theology, and education comprise the Commission. The basic criterion for membership is involvement in development, implementation, and evaluation of integrated services and interprofessional education.

The NCLIE comes together to share lessons learned and to connect with others who are creating family-centered, culturally competent, community-based education, health, and human service systems. The Commission shares its ideas and products through meetings of the participating professions. The last such meeting was held in conjunction with the American Academy of Pediatrics' (AAP) CATCH (Community Access to Child Health) national meeting in May 1997. The NCLIE has long sought a broader conversation with pediatricians regarding the health of children in their communities; the joint NCLIE-CATCH meeting provided a forum.

At the meeting, NCLIE members shared progress reports on the MCHB Demonstration Projects, and they participated in training sessions on Improving Child Health in Your Community with CATCH program directors from all parts of the United States. Concurrent sessions were held on 1) Needs Assessment, 2) Coalition Building, 3) Program Evaluation, and 4) Motivating Colleagues and Community. NCLIE members met with CATCH facilitators from their regions and were invited to participate in regional activities throughout the year, perpetuating important linkages at the regional level.

A highlight of the NCLIE-CATCH meeting was the presentation by Dr. Florene Poyadue, Director of Parents Helping Parents, titled "Families Are the Connecting Link." Dr. Poyadue identified how families can

Poyadue asserts that specific values and beliefs are essential to development of family-centered, culturally competent, community-based integrated services. Service providers must believe that families seek to act in the best interests of their children, families are the experts on their children, families can be trusted, families must be supported in ways that help them maintain their integrity, and families should be equal partners in their relationships with professionals.

be partners in improving preparation of service providers and delivery of services. Since the family is served by multiple professions and agencies, the family can be the link across the professions. Furthermore, they can connect service providers with other families who need assistance. The primary role of service providers, then, is to create the conditions that enable families to act on their own behalf. Each integrated service and interprofessional training program is unique and must emerge from the cultural setting in which it will operate; it cannot be transplanted from another setting, but must be developed with the families it will serve.

NCLIE members also participated in the Third National Conference on Interprofessional Education and Community Collaboration held in Kansas City. Also, many are currently involved in new collaboration initiatives developed by the Department of Health and Human Services and the Department of Education that focus on the development of family-centered integrated service systems. NCLIE's priority this year is dissemination. It is working with the Higher Education for Integrated Service Providers project at Western Oregon State College to enhance visitations and to share ideas and resources. Dissemination of "best practices" is progressing through interprofessional presentations at state, national, and international meetings and through publications in progress that describe integrated education, health, and human service programs and the interprofessional training and research programs that support them. Finally, the NCLIE is working with CATCH to plan a joint meeting in 1999 to share experiences on products with others who have been involved in developing interprofessional training programs.

Higher Education Curricula for Integrated Service Providers

Overall, the project has been successful in moving towards its goals. Each of the three model sites (California State University at Fresno, University of New Mexico, and University of Southern California) has made excellent progress toward incorporating interprofessional training in their academic settings across education, health, and social work, at a minimum. They have also developed community practicum sites to demonstrate the groups collaborating to deliver wrap-around services to children and their families.

CSU has developed a powerful curriculum that educates a cohort of students from nursing, social work, and education on a common set of courses and places them together in a community school setting for their practicum experience in an interprofessional working environment. CSU has had a request to replicate the program with the faculty and students at Western Kentucky University. They now have a video available that describes their program. The staff have also been successful in getting the University to approve a special credential recognizing the students who have completed the interprofessional training.

The UNM has developed its interprofessional approach with clinics that serve drug affected mothers and their children. The model uses equal partners from early education, social work, law, medicine, practicing physicians, and parents who have "graduated" from the program. Now, a new site in Spokane, Washington, Casey Family Partners, has agreements with the working staff to replicate the interprofessional approach developed at UNM. Eastern Washington University is also interested in duplicating UNM's academic training with graduate and undergraduate students.

USC has refined their interprofessional training to include social work, education, and some medical intervention in the University training programs as well as an inner city school site. They now have an opportunity to expand their interprofessional model to the Pediatric and Family Medical Center in South Central Los Angeles. Besides demonstrating how a complete service clinic should work, they will also train staff from pediatrics, dentistry, occupational therapy, physical therapy, social work education, and public administration.

The project has also been working on an "implementation analysis" instrument that lends itself to measuring progress as a site moves closer to operating a model at a truly interprofessional level. This approach can be used not only to document the "state" of a project but also as a baseline against which to measure gain. Potentially, it could be used diagnostically to examine what must be included to achieve an interprofessional approach. This instrument and approach are being further tested and refined with the hope they can become useful tools to assess programs and suggest areas of improvement.

The project's efforts to conduct thorough literature reviews and to produce bibliographies on the state-of-the-art in interprofessional education have been very successful. We have completed two such documents and are working on the third. The request for these materials has exceeded all of our expectations. In addition, we have produced a regular newsletter, *Service Bridges*, which has been immensely popular.

Partnerships for Change (PFC)

PFC continues to focus on promoting family/interprofessional collaborative practice, an approach that is essential to improving services for children with special health care needs and their families. Throughout the life of the grant, family/interprofessional collaboration has been integral to all project activities. Family/professional collaboration and interprofessional collaboration are often considered separately, both in literature and in practice. However, PFC has learned that an integrated family/interprofessional collaborative approach is key to providing high quality services. PFC's publication, *Partnerships at Work: Lessons Learned from Programs and Practices of Families, Professionals, and Communities* (Bishop, Taylor, Arango, 1997) gives examples of family/interprofessional collaboration in action. The book contains families' and professionals' stories about successes and challenges, and over 500 copies have been distributed.

PFC continues to work with the University of Vermont Department of Social Work in several education-related activities. *Integrating Family-Centered Interprofessional Content into the Social Work Curriculum: A Teaching Resource* will soon be completed. This teaching resource includes information on family-centered interprofessional practice, case examples, suggested teaching strategies, student activities and class exercises, and a reading list, and it will be available this summer. A

paper summarizing what has been learned through focus groups, surveys, and journalizing about preparing professionals for family/interprofessional collaborative practice is also in preparation.

PFC conducts qualitative research with families and children with special health care needs in order to describe the relationship between what they want and need for their children and the services that agencies and professionals provide. Preliminary findings suggest that care coordination is not a reality for many families, who continue to experience their systems of services as fragmented and confusing. In addition, even when there are many skilled professionals involved, families' priorities are often unaddressed. Professionals tend to do what they are trained to do and to offer what their agencies offer. Meeting the needs that families identify requires professionals to view their roles and agency functions flexibly and to develop additional resources in the community. A paper, "A New Paradigm for Providing High Quality Services to Children and their Families," will place family/interprofessional collaborative practice into context as one of the processes through which family-centered, community-based, culturally competent, and coordinated approaches are implemented.

As a member of the Board of Directors of Family Voices, PFC's Project Director, Kathleen Kirk Bishop, D.S.W., participated in their Annual Meeting and National Coordinator Training Conference in February. The focus of her presentation was the strategic planning process, which has been an ongoing collaboration between Family Voices and PFC. In March, Dr. Bishop partnered with two parents, Connie Wells of Florida and Gail Johnson of Maryland, and Carol Hassler, M.D., Director, Children with Special Health Needs, Vermont Department of Health, to present a program entitled, "Building Partnerships for Healthier Families: How to Effectively Involve Families, Communities, and the Private Sector in MCH/CSHN Issues." This workshop was part of the Annual Meeting of the Association of Maternal and Child Health Programs (AMCHP). With Dean Corrigan, Ed.D., Dr. Bishop presented a paper and a multimedia program at the 2nd International Conference on Social Work in Health and Mental Health in Melbourne, Australia. Dr. Bishop participated on a panel with the NCLIE at the Annual Meeting of the American Association of Colleges for Teacher Education.

Although the grant will end this year, the work of PFC will continue through Dr. Bishop's teaching, training, and consultation. Family-centered interprofessional collaboration has been thoroughly integrated into the social work curriculum (both classroom and field) at UVM, and Dr. Bishop is involved in an ongoing collaboration with the Council on Social Work Education with the goal of including interprofessional collaboration as a required competency in all social work programs. PFC's teaching resource, ***Integrating Family-Centered Interprofessional Content into the Social Work Curriculum***, will continue to be field-tested and disseminated, and all of the written materials which PFC has developed will remain available.

Publications available include: ***Partnerships at Work: Lessons Learned from Programs and Practices of Families, Professionals, and Communities*** (Bishop, Taylor, & Arango, 1997); "Creating Family-Centered Integrated Service Systems and Interprofessional Education Programs to Implement Them" (Corrigan & Bishop, 1997); a monograph, ***Family/Professional Collaboration for Children with Special Health Needs and Their Families*** (Bishop, Woll, & Arango, 1993); ***MSW Field Education Manual*** (Cass, 1995), which includes required interprofessional experiences; ***Interprofessional Education and Practice: A Selected Bibliography***, published by the Council on Social Work Education; a bibliography on family-authored and family/professional co-authored literature; PFC ***Information Exchange*** bulletins; and training resources and position papers in preparation.

For more information, please contact: Kathleen Kirk Bishop, D.S.W., Project Director, PFC, University of Vermont, Department of Social Work, 228 Waterman Building, Burlington, VT, 05405-0160, (802) 656-1156, e-mail: kbishop@zoo.uvm.edu, web page: http://www.ichp.edu/mchb/pfc.

Appendix B: Summary of *Training on Family-Centered Interprofessional Collaboration*

The manual consists of activities designed to promote the attitudes, skills, and knowledge required to provide services that are family-centered, specifically through interprofessional collaboration.

In defining the "medical home," the American Academy of Pediatrics (1992) asserts that the medical care of infants, children, and adolescents ideally should be accessible, continuous, comprehensive, family-centered, coordinated, and compassionate. It should be delivered by a physician who is known to the child and family and is able to develop a relationship of mutual responsibility and trust with them. The medical home provides health and psychosocial counseling. It should also include meaningful interaction with school and community agencies. Family-centered interprofessional collaboration enhances the medical home.

The *Training on Family-Centered Interprofessional Collaboration* takes a multi-faceted, experiential approach to these issues. Activities include group discussion and problem solving, worksheets, mini-lectures, and communication exercises. To obtain a copy of the manual, contact Sharon Taba at the Hawaii Medical Association, 1360 S. Beretania St., 2nd Floor, Honolulu, Hawaii, 96814, phone: (808) 536-7702, fax: (808) 528-2376, e-mail: s_taba@aloha.net.

Training Outline

Part I: Family-Centered Care

Section I: Elements of Family-Centered Care

- Introduces family-centered care
- Includes scenarios of relevant family issues which impact upon pediatric care, such as behavioral and educational consequences of health problems, divorce, domestic violence, and teen pregnancy

Section II: Respecting Family Diversity

- Explores working with families from different cultures (defined by race, religion, ethnicity, socioeconomic status, etc.)
- Suggests strategies for becoming culturally responsive

Section III: Children with Special Needs

- Explores the special health, educational, and social needs of children with developmental delays and those who are biologically or environmentally at risk for developmental delays

Section IV: Open Communication with Families

- Suggests guidelines for effective communication with families in situations such as breaking diagnostic news or interviewing families regarding psychosocial problems

Part II: Interprofessional Collaboration

Section I: The Need for Interprofessional Collaboration

- Discusses the multiple, interrelated factors that produce health, educational, and social challenges for children within families and families within society
- Focuses on the benefits of collaboration

Section II: Philosophies of the Roles

- Explores the roles of the medical home, early childhood educators, and social workers and how they are interdependent in serving families
- Suggests strategies for helping families access services

Section III: Integration of the Roles

- Provokes solution-oriented discussion about overcoming barriers to interprofessional collaboration with a primary focus on professionals' different beliefs and expectations

Section IV: Good Communication is Key to Successful Collaboration

- Creates opportunities for participants to understand their own and others' communication styles and to practice effective communication skills

Appendices

Appendix C: Summary of Interdisciplinary Seminar on Team Building in Interprofessional Education

This seminar will challenge teams composed of students from the schools of medicine, social work, and education to increase awareness of the positive value of interprofessional collaboration and to learn ways in which the principles of family-centered interprofessional collaboration (see page 5) can be applied to practice. The seminar objective is to expose students to two major schools of thought: 1) family-centered care is the most effective care in which families have opportunities to participate in major decisions regarding their child's health and education; and 2) interprofessional collaboration recognizes that professionals must work together in communities rather than independently to foster successful relationships with families.

As seminar participants, students spend their required practicum hours at a common practicum site. Weekly sessions must be attended by all members of the student team. Each of the sessions revolves around a theme and is guided by one of the seven principles of family-centered interprofessional collaboration. Assignments, readings, and discussions are based on the themes and principles, and students are required to continually assess their individual development during the practicum process. Written assignments may address areas of policy, community, organization, groups, families, and work with families. Weekly sessions last for two hours, and faculty members from the different schools and staff members from the practicum site share facilitation.

In addition to these weekly sessions, students complete team projects. First, they develop an team presentation on a topic selected with the site staff and families to present to the staff and/or families at the practicum site. Second, they identify families in transition (from Head Start to kindergarten, for example) and assist and learn from those families, with their permission and involvement, what the transition process requires, focused on the families' social, health, or education concerns.

The seminar covers two semesters or twenty-two sessions. The sessions use a variety of materials from different sources, including articles, texts, and videotapes. The related activities listed below are from *Training on Family-Centered Interprofessional Collaboration* (Iwaishi et al., 1998), described in Appendix B. That training manual, along with a detailed seminar outline and full description of seminar readings, activities, and requirements, is available from Sharon Taba, Hawaii Medical Association, 1360 S. Beretania Street, Second Floor, Honolulu, HI 96814, (808) 536-7702, e-mail: s_taba@aloha.net.

Seminar Outline (Developed by Ron Matayoshi, Linda McCormick, and Louise Iwaishi)

- **Seminar Overview**
  Activity: What Is Family-Centered Care?
- **Collaboration and Interagency Coordination** (Parts 1 and 2)
  Activities: What Is Interprofessional Collaboration?, What Are the Benefits of Collaboration?
- **Respect** (Parts 1 and 2)
  Activity: Role Beliefs and Expectations
- **Knowledge is Golden**
- **Facilitative Management** (Parts 1 and 2)
- **Family-Centered Care Network** (Parts 1 and 2)
- **Trust** (Parts 1 and 2)
- **Communication/Listening** (Parts 1 and 2)
  Activities: Jargon, Friend or Foe?, Are You Really Listening?
- **Our Professional Roles**
- **Team Progress Review**
- **Cultural Diversity**
- **Negotiation/Mediation** (Parts 1 and 2)
- **Team Progress Review**
- **The Aloha Spirit** (Parts 1 and 2)

Appendix D: Four Years of Lessons Learned in Family-Centered Interprofessional Collaboration

Building a Shared Vision

- Collaboration is based on relationships.
- Collaboration must occur at all levels.
- Collaboration functions best when it is the result of "bottom up" rather than "top down" efforts.
- Start small.
- Collaboration must be based on *mutual* trust and respect.
- Build resilient relationships across service networks.
- Work both from the bottom up *and* from the top down.
- Stay focused.
- Strengthen trusting relationships within and across community networks.
- Clarify choices for support with families.
- Teams are the core of family-centered interprofessional collaboration for families with young children.
- Identify goals from the start, and clarify them regularly.
- Allow time to foster team commitment.
- Develop strategies to promote common purpose.
- Sustain trusting team relationships.
- Learn families' social and cultural beliefs and practices.

Staff/Team Recruitment and Development

- Leadership sets the tone.
- Personality counts.
- Commitment to collaboration is essential.
- A leader must keep the team focused on its purpose.
- A collaborative person must be competent, seasoned, and comfortable with ambiguity.
- Teach other team members what you are doing and why.
- Develop a team of collaborative leaders.
- True leaders follow the families' lead and help administration follow.
- Refine skills in the collaborative process.
- Communication is key to collaboration.
- Continue staff development in work with children and families.
- Create collaborative environments for team leaders to emerge.
- Schedule team meetings on a regular basis.
- Keep lines of communication open.

Training

- Provide training that is early and ongoing.
- Incorporate team building skills.
- Emphasize process as well as product.
- Provide "in vivo" models of training.
- Training must be integrated into service.
- Value the lessons students teach us.
- Keep the rich opportunities for training in community programs.
- Use the lessons students and family members teach us.
- Provide guided learning opportunities.
- Know your audience.

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- Utilize the expertise of staff, students, and families.
- Distinguish between interprofessional and professional competencies.
- Value peer learning.

Monitoring, Evaluation, Feedback, and Refinement

- Staff turnover compels supplementary training and attention to group process.
- Respect the need to "grow as you go."
- Clearly define useful outcomes.
- Seek evaluation and feedback at all levels of program service.
- Develop multilevel commitment to outcomes and the evaluation process.
- Choose competency-based evaluation.
- Integrate team input in ongoing project refinement.
- Listen to families.

Dissemination

- Target your audience.
- Target audiences committed to young children and families.
- Move towards the development and record of good interprofessional practices which can be applied to other programs and training.
- Establish an institutional and system-wide commitment to integrated service delivery.
- Communicate outcomes to families, communities, and training institutions.
- Produce useable, high-impact collaborative materials.

Appendix E: Overview of Course Competencies for Practicum Students – University of Hawaii

Community Health Rotation – Pediatric Level I (School of Medicine)

- Understand the needs, beliefs, and prescriptives for families and know how to provide care to children within the patient's family system.
- Recognize the importance of understanding, accepting, and appreciating cultural diversity in one's patients and learn about the health-related implications of cultural beliefs and practices represented in one's community.
- Understand how to use private, public, and community resources to meet the needs of specific populations and individuals.
- Understand the multiple child advocacy roles in which pediatricians can participate.

Special Education (College of Education)

- Demonstrate systematic teaching procedures with students who have severe disabilities.
- Collaborate with related service professionals to provide integrated therapy in inclusive settings.
- Demonstrate sensitivity to diversity by practicing activities that value students' cultural backgrounds.
- Collaborate with parents by addressing parents' concerns, supporting parents' participation in their children's education, and communicating regularly with parents regarding students' strengths, progress, and educational needs.

Social Work (School of Social Work)

- Demonstrate knowledge and ability to apply the generic model of social work practice to interventions with individuals, families, groups, organizations, and communities.
- Demonstrate knowledge and ability to apply a selected range of practice theories to interventions with individuals, families, groups, organizations, and communities.
- Demonstrate knowledge and ability to apply social work values and ethics to practice situations.
- Demonstrate cultural competency (knowledge of and sensitivity to cultural strengths, values, and beliefs) and ability to work effectively with people from diverse racial, ethnic, and cultural backgrounds.

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PACT: Kuulei Richard, Director, Early Head Start and Head Start Programs; Po Kwan Wong, Program Manager

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HRTL: Lisa Carlson, Early Childhood Educator; Mel Hayase, Social Worker; Dianne Wakatsuki, Nurse Practitioner

Students: Special Education Doctoral Candidate, Early Childhood Education Master's Student, Social Work Master's Student

Interprofessional Meetings (Convened September, 1997 through April, 1998):

Attended by the student team, including pediatric residents during their rotations, Louise Iwaishi, Ron Matayoshi, Linda McCormick, Kuulei Richard, Po Kwan Wong, Carol Hosaka, Anita Choy, Corina Moefu, Jo Jo Texeira, Sharon Taba, Lynn Yamashita, and Anne Ambrose.